2011 WL 5186155 (Ga.State Ct.) (Trial Pleading)
Georgia State Court.
Dekalb County

Arethia JOHNSON, as Administrator of the Estate of Irene Boswell, and John Holt in his Representative Capacity on Behalf of the Children of Irene Boswell, Plaintiff,

v.

MANOR CARE REHABILITIATION CENTER of Decatur GA, LLC, HCR Manorcare Properties, LLC and Dekalb Medical Center, Inc., Defendants.

No. 11A39302.
October 14, 2011.

Complaint for Damages

By Counsel, Law Offices of Daniel W. Cotter, P.C., Daniel W. Cotter, Ga. Bar No. 189599, 910 Church Street, Suite 202, Decatur, GA 30030, (404) 377-5775.

Law Office of George S. Johnson, LLC, George S. Johnson, Ga. Bar No.: 393507, 910 Church Street, Suite 202, Decatur, GA 30030, (404) 378-5878.

COMES NOW Plaintiffs, ARETHIA JOHNSON, as Administrator of the ESTATE OF IRENE BOSWELL, and JOHN HOLT in his Representative Capacity on Behalf of the Children of IRENE BOSWELL, and file this Complaint for Damages against the Defendants, MANOR CARE REHABILITATION CENTER OF DECATUR GA, LLC, HCR MANORCARE PROPERTIES, LLC and DEKALB MEDICAL CENTER, INC., and alleges as follows:

Preliminary, Venue, and Jurisdiction Allegations

1. Plaintiffs, ARETHIA JOHNSON is the duly appointed Administrator of the ESTATE OF IRENE BOSWELL, having been so appointed on December 23, 2010, in the Probate Court of DeKalb County, Georgia. A copy of the Letters of Administration is attached hereto as *Exhibit "A"*, and Plaintiff brings the survival actions in that capacity.

2. IRENE BOSWELL died on October 19, 2010, leaving no surviving spouse and two children. JOHN HOLT and MARY WRIGHT are the children of IRENE BOSWELL. JOHN HOLT brings this wrongful death action in her representative capacity on behalf of all of the statutory wrongful death beneficiaries of IRENE BOSWELL. A copy of the Death Certificate of IRENE BOSWELL is attached hereto as *Exhibit "B"*.

3. Defendant MANOR CARE REHABILITATION CENTER OF DECATUR GA, LLC (hereinafter referred to as "Manor Care of Decatur") is an Delaware limited liability company, and, upon information and belief, is authorized to do business in the State of Georgia, and was, upon information and belief, at all times applicable to this Complaint, engaged in the business of owning, managing, and/or operating the facility known as MANORCARE REHAB CENTER - DECATUR, located in DeKalb County, Georgia. A copy of the DHR Disclosure of Ownership of ManorCare Rehab Center - Decatur is attached hereto as *Exhibit "C"*. According to the Georgia Secretary of State, Manor Care of Decatur may be served through its registered agent, Corporation Process Company, 2180 Satellite Blvd, Suite 400, Duluth, Gwinnett County, Georgia 30097. See *Exhibit "D"*.

4. Defendant, HCR MANORCARE PROPERTIES, LLC is an Delaware corporation, and, upon information and belief, is authorized to do business in the State of Georgia, and was, upon information and belief, at all times applicable to this Complaint,

engaged in the business of owning, managing, and/or operating the facility known as MANORCARE REHAB CENTER - DECATUR, located in DeKalb County, Georgia. A copy of the DHR Disclosure of Ownership of Beverly Manor of Augusta is attached hereto as *Exhibit "C"*. According to the Georgia Secretary of State, HCR MANORCARE PROPERTIES, LLC may be served through its registered agent, Corporation Process Company, 2180 Satellite Blvd., Suite 400, Duluth, Gwinnett County, Georgia 30097. See *Exhibit "E"*.

5. Defendant, DEKALB MEDICAL CENTER, INC., a Georgia corporation, is authorized to do business in the State of Georgia, is actively engaged and transacting business in Georgia, and maintains its registered agent and office in DeKalb County, and was, at all times applicable to this Complaint, engaged in the business of operating a hospital facility known as DeKalb Medical Center, Inc., in DeKalb County, Georgia, operating at 2701 North Decatur Road, Decatur, DeKalb County, Georgia 30033. DEKALB MEDICAL CENTER, INC., may be served through its registered agent, Eric P. Norwood, 2701 North Decatur Road, Decatur, DeKalb County, Georgia, 30033. DEKALB MEDICAL CENTER, INC., is subject to the jurisdiction of this Court and venue is proper as to DEKALB MEDICAL CENTER, INC., in this Court. See *Exhibit "F"*.

6. Defendants, MANOR CARE REHABILITATION CENTER OF DECATUR GA, LLC, HCR MANORCARE PROPERTIES, LLC and DEKLB MEDICAL CENTER, INC., are subject to the venue and jurisdiction of this Honorable Court, and are, for purposes of this action, considered to be joint tortfeasors for purposes of venue.

7. At all times material hereto, Defendant, DEKALB MEDICAL CENTER, INC., was engaged in the business of owning, operating, and/or managing the hospital facility known as DEKALB MEDICAL CENTER, and was responsible to the patients of its facility, including IRENE BOSWELL, for the provision of her custodial care and treatment, and the provision of appropriate nursing services.

8. At all times material hereto, Defendants, MANOR CARE REHABILITATION CENTER OF DECATUR GA, LLC, and HCR MANORCARE PROPERTIES, LLC were engaged in the business of owning, operating, and/or managing the nursing home facility known as MANORCARE REHAB CENTER - DECATUR, and were responsible to the residents of its facility, including IRENE BOSWELL, for the provision of her custodial care and treatment, and the provision of nursing home services, including, but not limited to, the provisions of residents' rights.

9. The duties Defendants, MANOR CARE REHABILITATION CENTER OF DECATUR GA, LLC, and HCR MANORCARE PROPERTIES, LLC owed to IRENE BOSWELL while She was a resident at their facility included the duty to provide him with that degree of care, skill, and diligence usually exhibited by nursing homes generally in the community, and the duties set forth in *Bill of Rights for Residents of Long-Term Care Facilities* as set forth in O.C.G.A. §§31-8-104 through 31-8-121.

10. The duties Defendant DEKALB MEDICAL CENTER, INC., owed to IRENE BOSWELL while she was a resident at its hospital included the duty to provide her with that degree of care, skill, and diligence usually exhibited by hospitals and nursing staffs generally in the community.

11. Pursuant to O.C.G.A. §9-11-9.1(a), to the extent that statute may even apply to this action, attached hereto and incorporated herein as *Exhibit "G"*, is the Affidavit of Debi Luther, RN, NHA, who is qualified as an expert witness on the issues raised in this Complaint. The Affidavit specifies at least one negligent act or omission on the part of Defendants, MANOR CARE REHABILITATION CENTER OF DECATUR GA, LLC, and HCR MANORCARE PROPERTIES, LLC, and/or their staff, and the factual basis for such negligent act or omission that caused injury to IRENE BOSWELL. The Affidavit is not inclusive of each act, error, or omission that has been committed, or may have been committed by the Defendants, MANOR CARE REHABILITATION CENTER OF DECATUR GA, LLC, and HCR MANORCARE PROPERTIES, LLC, and Plaintiff reserves the right to contend and prove additional acts, errors, and omissions on the part of Defendants, MANOR CARE REHABILITATION CENTER OF DECATUR GA, LLC, and HCR MANORCARE PROPERTIES, LLC that reflect a departure from the requisite standard of care required by law.

12. Pursuant to O.C.G.A. §9-11-9.1(a), to the extent that statute may even apply to this action, attached hereto and incorporated herein as *Exhibit "H"*, is the Affidavit of Mary Lynn King, RN, BSN, CWOCN, who is qualified as an expert witness on the issues raised in this Complaint. The Affidavit specifies at least one negligent act or omission on the part of Defendant DEKALB MEDICAL CENTER, INC., and/or its staff, and the factual basis for such negligent act or omission that caused injury to IRENE BOSWELL. The Affidavit is not inclusive of each act, error, or omission that has been committed, or may have been committed by the Defendant DEKALB MEDICAL CENTER, INC., and Plaintiff reserves the right to contend and prove additional acts, errors, and omissions on the part of Defendant DEKALB MEDICAL CENTER, INC., that reflects a departure from the requisite standard of care required by law.

Background as to Manor Care Rehabilitation Center of Decatur GA, LLC, and HCR Manorcare Properties, LLC

13. Irene Boswell was seen in the ER at DeKalb Medical Center on July 5, 2010, for a syncopal episode. Because of her dementia, a PEG tube was placed on July 9, 2010. Her diabetes medication was adjusted and she continued to improve. The social worker informed the family that Ms. Boswell would most likely need skilled nursing care at discharge and the family chose Manor Care Rehabilitation Center of Decatur. Ms. Boswell was discharged to Manor Care Rehabilitation Center of Decatur on July 17, 2010 in stable condition.

14. On admission to Manor Care Rehabilitation Center of Decatur on July 17, 2010, Ms. Boswell's admission diagnosis included syncopal episode, malnutrition, hypertension, diabetes type 2, chronic renal insufficiency and a fall at home. No skin issues were present upon admission. On July 29, 2010, Ms Boswell pulled her PEG tube out and she was sent back to DeKalb Medical Center that same day. The PEG tube was replaced on July 30, 2010, and Ms. Boswell was discharged back to Manor Care Rehabilitation Center of Decatur on July 31, 2010, in stable condition.

15. On Ms. Boswell's return to Manor Care Rehabilitation Center of Decatur, dry skin was noted on her buttocks, and no other skin issues other than scars and the PEG tube site were noted. Ms. Boswell had several falls following this readmission. Of note, she was found on the floor on August 12, 2010, and was placed back in the bed. She complained of left knee pain and an x-ray was ordered, which was negative for a fracture at that time. On September 12, 2010, a fluid filled blister was noted to the right heel. Skin prep was applied and the heel was floated. A blood-filled blister was noted to the right heel on September 17, 2010. The blister was noted to be open on September 18, 2010.

16. On September 27, 2010, the nurse noted the left leg appeared swollen with redness. A new order was received for a venous ultrasound of the bilateral lower extremities and Keflex was ordered for cellulites of the left leg. The multi-podus boot was removed from the left foot and it appeared more swollen than the right at 6 a.m. on September 28, 2010, and the left inner ankle did not look right. Upon further assessment, a stage II open area was also noted to the coccyx. Irene Boswell was transferred to DeKalb Medical Center from Manor Care of Decatur on September 28, 2010, for left lower extremity swelling. She was admitted to DeKalb Medical Center for a bimalleolar ankle fracture and a fifth metatarsal fracture. Ms. Boswell also had a sacral decubitus ulcer and decubitus ulcer to the right heel at the time. Surgery was done to repair the fractures on September 29, 2010. Irene Boswell remained a patient there following the surgical repair until October 1, 2010, when she was discharged back to Manor Care of Decatur. Upon her return to Manor Care of Decatur, Ms. Boswell's sacral decubitus ulcer measured 4cm x 9cm and the right heel ulcer measured 8cm x 7cm with eschar and necrosis.

17. Ms. Boswell was re-admitted to DeKalb Medical Center on October 12, 2010, with a decubitus ulcer that was a stage III-IV on her sacrum with foul smell and erythema and drainage. She was admitted for a fever thought to be sepsis from the ulcer. Her WBC on October 12, 2010, was 20.4. A blood culture was taken and she was found to have coagulase negative staph in her blood. She was started on Zosyn and Vancomycin. There was also a decubitus sore on her right heel with eschar as well as contractures to the upper and lower extremities. She was noted to be nonverbal and staring straight ahead. She was discharged to Odyssey Hospice on October 15, 2010 where she continued to decline and passed away on October 19, 2010.

18. While a resident of MANORCARE REHAB CENTER - DECATUR, IRENE BOSWELL suffered from preventable pressure sores (bedsores) and the worsening thereof, infections, dehydration, neglect, painful and excruciating fractures of unknown origin, delays in the provision of care, inadequate preventative custodial skin care, and inconsistent and inappropriate documentation, as well as the other injuries enumerated herein.

19. In order to properly care for IRENE BOSWELL, these Defendants were required by the applicable standards of care to provide accurate nursing documentation of her condition to be used for continuity of care; to provide adequate and appropriate skin care so as to prevent pressure sores and the worsening thereof; to provide adequate and appropriate hydration so as to prevent dehydration; to provide adequate custodial care to prevent broken bones and serious injury; and to provide proper nursing care all within accepted professional standards and practices. The standards of care required of these Defendants to provide these services in a reasonably prudent manner, and by its continued acceptance of IRENE BOSWELL as a patient and resident, these Defendants agreed to do so.

20. These Defendants knew or should have known that a patient or resident in the condition of IRENE BOSWELL could and would very likely suffer bedsores and the worsening thereof, dehydration, and suffer broken bones and other serious injuries if the appropriate preventative measures were not taken, and if she was not appropriately cared for, monitored, and attended to. Nonetheless, these Defendants failed to take adequate and appropriate measures to prevent these conditions from occurring, and once these conditions occurred, these Defendants repeatedly failed to adequately and appropriately care for IRENE BOSWELL.

21. The injuries and conditions referenced in the above paragraph required extensive medical care and treatment, and were painful and disfiguring to IRENE BOSWELL, and ultimately led to her death.

Background as to DeKalb Medical Center

22. Irene Boswell was transferred to DeKalb Medical Center from Manor Care of Decatur on September 28, 2010, for left lower extremity swelling. She was admitted to DeKalb Medical Center for a bimalleolar ankle fracture and a fifth metatarsal fracture. Ms. Boswell also had a sacral decubitus ulcer and decubitus ulcer to the right heel at the time. Surgery was done to repair the fractures on September 29, 2010.

23. On September 28, 2010, while Irene Boswell was stable, and in no acute distress, the nursing staff, agents and employees of DeKalb Medical Center failed to perform a proper nursing assessment and failed to provide, document or record turning or repositioning while Ms. Boswell spent nearly 10 hours on a stretcher. On September 28-29, 2010, after Irene Boswell's admission to the hospital, the nursing staff, agents and employees of DeKalb Medical Center failed to perform a proper nursing assessment and failed to provide, document or record turning or repositioning during the entire 11:00 p.m. to 7:00 a.m., shift and the 3:00 p.m. to 11:00 p.m. shift. On September 30, 2010, after Irene Boswell's admission to the hospital, the nursing staff, agents and employees of DeKalb Medical Center failed to perform a proper nursing assessment and failed to use, document or record placement of heel protective devices as ordered for her heel pressure sores during the entire day.

24. Irene Boswell remained a patient at DeKalb Medical Center following the surgical repair for her fractures until October 1, 2010, when she was discharged back to Manor Care of Decatur. Upon her return to Manor Care of Decatur, Ms. Boswell's sacral decubitus ulcer measured 4cm x 9cm and the right heel ulcer measured 8cm. Ms. Boswell was re-admitted to DeKalb Medical Center on October 12, 2010, with a decubitus ulcer that was a stage III-IV on her sacrum with foul smell and erythema and drainage. She was admitted for a fever thought to be sepsis from the ulcer. Her WBC on October 12, 2010, was 20.4. A blood culture was taken and she was found to have coagulase negative staph in her blood. She was started on Zosyn and Vancomycin. There was also a decubitus sore on her right heel with eschar as well as contractures to the upper and lower extremities. She was noted to be nonverbal and staring straight ahead. She was discharged to Odyssey Hospice on October 15, 2010 where she continued to decline and passed away on October 19, 2010.

25. In order to properly care for IRENE BOSWELL, DEKALB MEDICAL CENTER nursing personnel were required by the applicable standards of care in the industry to maintain careful supervision of IRENE BOSWELL in order to prevent the development and/or worsening of pressure sores; to utilize proper pressure reduction techniques to prevent the development and/or worsening of pressure ulcers; to timely notice the development of any new pressure ulcers; to diagnose and treat any pressure ulcers which did develop; to accurately assess and treat skin conditions once they occurred; to assist IRENE BOSWELL with turning and repositioning and with all activities of daily living, including keeping her clean and dry; to keep IRENE BOSWELL properly hydrated and nourished; to properly monitor and assess IRENE BOSWELL'S hydration and nutritional status; and to maintain clinical records on each resident in accordance with accepted professional standards and practices. The standards of care in the nursing profession required DEKALB MEDICAL CENTER nursing staff to provide IRENE BOSWELL with nursing services with that degree of skill and care which under similar conditions and like surrounding circumstances is ordinarily employed in the profession generally.

26. DEKALB MEDICAL CENTER was negligent and failed to exercise the degree of care, skill and diligence generally exercised by hospital nursing staffs under the same or similar circumstances in its care and treatment of IRENE BOSWELL.

27. The Defendant, DEKALB MEDICAL CENTER, knew or should have known that a patient in the condition that IRENE BOSWELL was in, could and would very likely suffer pressure sores (bedsores), or the worsening thereof, including infections, if she was not appropriately cared for, monitored, and attended to. Nonetheless, Defendant, DEKALB MEDICAL CENTER, failed to take adequate and appropriate measures to prevent these injuries and conditions from occurring, and once these injuries and conditions occurred, Defendant, DEKALB MEDICAL CENTER, failed to adequately and appropriately care for IRENE BOSWELL, all of which ultimately led to her injuries and death.

28. The injuries and conditions referenced in the above paragraph required extensive medical care and treatment, and were painful and disfiguring to IRENE BOSWELL.

COUNT I

Statutory Cause of Action Brought Pursuant to the Provisions of the Bill of Rights for Residents of Long-Term Care Facilities against Defendants Manor Care Rehabilitation Center of Decatur GA, LLC, and HCR Manorcare Properties, LLC

29. Plaintiff, ARETHIA JOHNSON, realleges and incorporates by reference Paragraphs 1 through 21, above, as if each were fully set forth herein.

30. At all times material hereto, these Defendants' nursing home known as MANORCARE REHAB CENTER - DECATUR was a “facility,” as defined by the provisions of O.C.G.A. 31-8-102 (3), being operated by these Defendants, and was subject to the regulation of, and licensure by, the Georgia Department of Human Resources.

31. At all times material hereto, IRENE BOSWELL was a “resident” of the facility known as MANORCARE REHAB CENTER - DECATUR as defined by the provisions of O.C.G.A. §31-8-102 (5).

32. By virtue of the provisions of O.C.G.A. §§31-8-104 through 31-8-121, IRENE BOSWELL was entitled to have certain rights provided for and protected while he was a resident at these Defendants' facility. Those resident's rights included, but were not limited to, the following:

§31-8-108

(a) Each resident shall receive care, treatment, and services which are adequate and appropriate. Care, treatment, and services shall be provided as follows:

(1) With reasonable care and skill;

(2) In compliance with applicable laws and regulations;

(3) Without discrimination in the quality of a service based on a source of payment for the service;

(4) With respect for the resident's personal dignity and privacy;

(b) In the provision of care, treatment, and services to the resident by the facility, each resident or guardian shall be entitled to the following:

(1) To choose the resident's physician.

(2) To participate in the overall planning of the resident's care and treatment. The resident or guardian shall be informed of this right each time a substantial change in the treatment is made;

(3) To have any significant change in the resident's health status reported to persons of his choice by the facility within a reasonable time;

§31-8-114

(4) ...the right to respect and privacy in his medical, personal, and bodily care program.

33. IRENE BOSWELL was aggrieved because these Defendants violated or failed to provide for his resident rights while he was resident at MANORCARE REHAB CENTER DECATUR.

34. By virtue of the provisions of O.C.G.A. §31-8-126(a), Plaintiff has a separate cause of action against these Defendants for each of those injuries and damages, which arose from the violations of, and failures to provide for IRENE BOSWELL'S statutorily protected nursing home resident rights.

35. These Defendants' responsibilities to IRENE BOSWELL as outlined above were non-delegable and these Defendants have direct liability for violations of, and failures to provide for deprivations and infringements of said rights by any person or entity under their control, direct or indirect, including their employees, agents, consultants and independent contractors, whether in-house or outside entities, individuals, agencies or pools, or caused by these Defendants' policies, whether written or unwritten, or common practices.

36. Notwithstanding the responsibility of these Defendants to provide IRENE BOSWELL with his statutorily mandated and protected nursing home resident rights as set forth herein, IRENE BOSWELL was deprived of such rights by the acts or omissions of these Defendants, such acts and omissions which include, but are not limited to, the following:
(a) Failed to take adequate and appropriate skin care precautions to prevent the development of skin breakdown and the worsening thereof;

(b) Failed to provide IRENE BOSWELL with adequate hydration;

(c) Failed to provide an adequately hygienic environment so as to prevent infection and the spread thereof;

(d) Failed to prevent broken bones and other serious injuries;

(e) Failed to provide sufficient staff to meet IRENE BOSWELL'S needs;

(f) Failed to provide adequate nursing care;

(g) Failed to provide a safe environment;

(h) Failed to follow physician's orders;

(i) Failed to notify the physician of changes in condition;

(j) Failed to provide proper care and services in accordance with resident's rights;

(k) Failed to provide watchful oversight and protective care of IRENE BOSWELL;

(1) Failed to provide adequate nursing services;

(m) Failed to obtain necessary medical services in a timely manner;

(n) Failed to properly supervise staff;

(o) Failed to properly train staff;

(p) Failed to properly perform staff retention;

(q) Failed to protect the privacy and dignity of IRENE BOSWELL; and

(r) Failed to provide proper care and services in accordance with the resident's needs.

37. In addition to these Defendants' direct responsibility under O.C.G.A. §§31-8-104 through 31-8-121 above, these Defendants have vicarious liability for the acts and omissions of all persons or entities under their control either direct or indirect, including their employees, agents, and consultants, for violations of, and failures to provide for IRENE BOSWELL'S resident rights.

38. The duties alleged in the immediately preceding paragraphs include, but are not limited to, proper training and supervision; proper hiring, background and referral checks; and proper retaining and dismissing of employees, agents, consultants and independent contractors.

Damages

39. As a direct and proximate result of the violations of, and the failures to provide for IRENE BOSWELL'S resident rights by these Defendants as described herein, IRENE BOSWELL has been aggrieved and suffered injuries, physical and mental pain and suffering, disability, physical impairment, disfigurement, inconvenience, and loss of capacity for enjoyment of life, and ultimately died. Further, her estate incurred medical expenses and funeral expenses related to her rights being violated.

40. Plaintiff, ARETHIA JOHNSON, brings this action in her capacity as Administrator of the ESTATE OF IRENE BOSWELL, to recover damages for the mental, physical and emotional pain and suffering of IRENE BOSWELL prior to her death, to recover damages for her death, and also to recover those medical and funeral expenses that resulted from the deprivations and infringements upon IRENE BOSWELL'S resident rights by these Defendants, all of which such damages resulted from the violations of, and the failures, to provide for IRENE BOSWELL'S resident rights by these Defendants.

41. These Defendants, by their failure to provide adequate services, care, and treatment, and their failure to provide for IRENE BOSWELL'S rights, showed willful misconduct, malice, wantonness, and entire want of care that constitutes a conscious indifference to the consequences. Therefore, Plaintiff may be entitled to recover, pursuant to O.C.G.A. §51-12-5.1, an award of punitive damages to punish, penalize and deter these Defendants, and others similarly situated, from repeating such conduct.

WHEREFORE, Plaintiff, ARETHIA JOHNSON, as Administrator of the ESTATE OF IRENE BOSWELL, demands trial by jury and judgment against Defendants, MANOR CARE REHABILITATION CENTER OF DECATUR GA, LLC, and HCR MANORCARE PROPERTIES, LLC for compensatory and punitive damages in an amount to be determined by a jury, and such costs and attorney's fees as may be appropriate under Georgia law.

COUNT II

Survival Negligence Claims against Defendants Manor Care Rehabilitation Center of Decatur GA, LLC, and HCR Manorcare Properties, LLC

42. Plaintiff, ARETHIA JOHNSON, realleges and incorporates by reference Paragraphs 1 through 21, above as if they were fully set forth herein.

43. By virtue of the provisions of O.C.G.A. §9-2-41, IRENE BOSWELL'S actions and causes of action for the recovery of damages for injuries to her person prior to her death do not abate by her subsequent death, and survive to the Administrator of the ESTATE OF IRENE BOSWELL.

44. By its acceptance of IRENE BOSWELL as a resident at their nursing home facility, these Defendants owed her a duty to furnish her with that degree of care, skill and diligence required of the nursing home profession in general under similar conditions and like surrounding circumstances.

45. These Defendants were negligent and failed to exercise that degree of care required of the long-term care and skilled nursing home profession in general under similar conditions and like circumstances. To the extent that this Count II may be considered a medical malpractice action as defined in O.C.G.A. §9-11-8 or O.C.G.A. §9-3-70, see the Affidavit of Debbi Luther, R.N., NHA, attached as Exhibit “G“ hereto pursuant to O.C.G.A. §9-11-9.1(a), to the extent that this statute may apply, if at all, to this action, and which Affidavit is hereby incorporated herein by reference. The Affidavit specifies at least one negligent act or omission on the part of these Defendants and/or their staff, and the factual basis for such negligent act or omission that caused injury to IRENE BOSWELL. The Affidavit is not inclusive of each act, error, or omission that has been committed by these Defendants, and Plaintiff reserves the right to contend and prove additional acts, errors, and omissions on the part of these Defendants that reflect a departure from the requisite standard of care required by law.

46. Notwithstanding the duty owed to IRENE BOSWELL by these Defendants as described above, these Defendants were negligent and failed to exercise that degree of care, skill and diligence required of the medical and nursing home profession in general under similar conditions and like circumstances. The negligence of these Defendants included, but was not limited to, the following:
(a) The Failure of MANOR CARE REHABILITATION CENTER OF DECATUR to Provide Adequate Supervision to Prevent Accidents. MANOR CARE REHABILITATION CENTER OF DECATUR was required by the standards of care to provide adequate supervision to prevent accidents. On July 17, 2010, Ms. Boswell was admitted to the facility with a history of having a fall at home. After admission, Ms. Boswell suffered five falls on July 22, 2010; July 28, 2010; August 3, 2010; august 12, 2010; and August 18, 2010. Finally, a care plan meeting was held on August 19, 2010 regarding the falls. However, an immediate care plan should have been done to provide intervention to prevent falls. Ms. Boswell was hospitalized immediately prior to her admission to the facility for a fall at home, and this should have an immediate care plan for falls and fall prevention. When a care plan was done for falls regarding Ms. Boswell, it was insufficient with no new interventions implemented such as a bed

or chair alarm after multiple falls. Additionally, Ms. Boswell had a PEG tube placed at the hospital prior to her admission to the facility on July 17, 2010. The hospital used an abdominal binder to keep the PEG tube secure because Ms. Boswell had a history of pulling at her lines. However, after Ms. Boswell arrived at Manor Care Rehabilitation Center of Decatur, the abdominal binder was not properly used, and she pulled her PEG tube out July 29, 2010. This should not have happened, and it would have been prevented if the facility had properly used the abdominal binder to secure the PEG tube. Due to Ms. Boswell's history of falls, and history of pulling at her lines prior to admission to the facility, proper fall care planning interventions should have been made at the time of her admission on July 17, 2010 including, without limitation, placing a bed and chair alarm for falls and properly using the abdominal binder to prevent dislodging of the PEG tube, as required by the professional standards of care required in the industry.

(b) The Failure to provide an adequate and appropriate Comprehensive Care Plan that describes the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. MANOR CARE REHABILITATION CENTER OF DECATUR was charged with performing an accurate assessment upon Ms. Boswell's admission, and on an ongoing basis, and that assessment would lead to the development of a care plan that had identified appropriate problems, goals, and interventions for the staff to follows. MANOR CARE REHABILITATION CENTER OF DECATUR fell below the standards of care required in that her chart was inconsistent regarding Ms. Boswell's toileting requirements. Due to her increasing dementia and her lack of safety awareness, Ms. Boswell should have been assessed for a scheduled toileting routine. The standards of care in the industry required MANOR CARE REHABILITATION CENTER OF DECATUR to prepare, implement and appropriately update a comprehensive care plan to prevent falls during Ms. Boswell's admission from July 17, 2010 through October 12, 2010. After admission, Ms. Boswell suffered five falls on July 22, 2010; July 28, 2010; August 3, 2010; August 12, 2010; and August 18, 2010. Finally, a care plan meeting was held on August 19, 2010 regarding the falls. However, an immediate care plan should have been done to provide intervention to prevent falls. Ms. Boswell was hospitalized immediately prior to her admission to the facility for a fall at home, and this should have an immediate care plan for falls and fall prevention. When a care plan was done for falls regarding Ms. Boswell, it was insufficient with no new interventions noted such as a bed or chair alarm even though she had multiple falls and it was evident the current interventions were inappropriate. The standards of care in the industry required MANOR CARE REHABILITATION CENTER OF DECATUR to prepare, implement and appropriately update a comprehensive care plan to prevent the development of decubitus ulcers. No MDS during Ms. Boswell's entire residency identified any of Ms. Boswell's wounds. The second MDS prepared for Ms. Boswell simply noted a history of a decubitus ulcer. Nursing notes identified a heel wound on August 12, 2010. A heel blister was noted as having opened on August 18, 2010. Physical therapy removed Ms. Boswell's multi-podus boot on August 24, 2010, and noted that she had a deep wound to the right heel and an ankle wound. By September 14, 2010, the physician ordered daily skin audits, and the care plan required physician and responsible party notification for deterioration and changes in condition for Ms. Boswell. This could not have been properly done because a wound to Ms. Boswell's sacrum was not noted by the facility until September 28, 2010, and it was identified as a Stage II at that time. Furthermore, Ms. Boswell went to the hospital at DeKalb Medical Center that same day and the hospital identified the sacral wound as a Stage III. By October 1, 2010, Ms. Boswell was not to be left in the supine position while in bed. However, the care plan was not updated to show that Ms. Boswell was to be kept off of her back. There was also no documentation that Ms. Boswell was turned side to side. In fact, she was documented as being found in the supine position in her bed after October 1, 2010. From the time Ms. Boswell returned to the facility from the hospital on October 1, 2010, to the time she left the facility for the last time on October 12, 2010, she was not noted to have any complications or signs of infection with her wounds such as a foul odor. During this time period there was no note that a physician was notified regarding any complications or changes in condition with Ms. Boswell's wounds. However, on October 12, 2010, Ms. Boswell was found to have a fever, and she was sent to the hospital where hospital staff found her decubitus ulcers to be infected Stage III -IV wounds, her WBC to be 20,000 and blood cultures confirmed sepsis with coagulase negative staph found in her blood. As a result of the inadequate care plans for toileting, fall prevention and wound prevention, Ms. Boswell suffered preventable falls, preventable skin breakdown and preventable wound infection and sepsis.

(c) ***The Failure to document skin breakdown issues in Ms. Boswell's MDS and improperly using LPN as MDS coordinator to certify MDS assessments where an RN is required by regulations for MDS assessment certification. 483.20.*** MANOR CARE REHABILITATION CENTER OF DECATUR was charged with performing accurate MDS assessments by a registered

nurse during Ms. Boswell's residency, and on an ongoing basis, and that MDS assessment would identify appropriate problems, goals, and interventions for the staff to follows. MANOR CARE REHABILITATION CENTER OF DECATUR fell below the standards of care required in that the MDS assessments did not document Ms. Boswell skin breakdown issues properly, and the MDS coordinator certifying the assessment was an LPN contrary to the requirements of federal regulation and was by regulation improperly and/or inadequately trained. As a result of the inadequate MDS assessments, Ms. Boswell suffered preventable skin breakdown and preventable wound infection and sepsis.

(d) ***The Failure to turn and reposition to prevent Ms. Boswell from being in the supine position.*** MANOR CARE REHABILITATION CENTER OF DECATUR was charged with properly turning and repositioning Ms. Boswell during Ms. Boswell's residency, and by July 31, 2010, Ms. Boswell was not to be left in the bed in the supine position pursuant to Interagency Patient Transfer Form when she was discharged from the hospital that day. MANOR CARE REHABILITATION CENTER OF DECATUR fell below the standards of care by leaving Ms. Boswell in the supine position and failing to document that the facility was turning her from side-to-side to avoid placing her in the supine position. Prevention measures to keep Ms. Boswell from being in the supine position in bed were not incorporated in her care plan or MDS assessments. This precaution was especially important where Ms. Boswell had added pressure where the head of her bed was at a 30 degree angle because of her PEG tube. As a result of the failure to properly turn and reposition Ms. Boswell, she suffered preventable skin breakdown and preventable wound infection and sepsis.

(e) *Failing to assess, intervene and prevent serious accidents.* On September 27, 2010, the nurse noted that Ms. Boswell's left leg appeared swollen with redness. A new order was received for a venous ultrasound of the bilateral lower extremities and Keflex was ordered for cellulites of the left leg. The multi-podus boot was removed from the left foot and it appeared more swollen than the right at 6 a.m. on September 28, 2010, and the left inner ankle did not look right. However, no one at the facility assessed any bony deformities to Ms. Boswell at that time. Irene Boswell was transferred to DeKalb Medical Center from Manor Care of Decatur on September 28, 2010, for left lower extremity swelling. Upon admission, the doctor noted an "obvious deformity of her distal tib-fib." She was admitted to DeKalb Medical Center for a bimalleolar ankle fracture and a fifth metatarsal fracture. The doctor and social worker with the hospital were so concerned with the injury as being possible **elder abuse** that they proceeded to contact adult protective services. MANOR CARE REHABILITATION CENTER OF DECATUR fell below the standards of care by failing to supervise Ms. Boswell to prevent accidents such as the bimalleolar ankle fracture and a fifth metatarsal fracture she suffered and the facility was unable to identify the origin of the injury. As a result of the failure to properly supervise and prevent accidents for Ms. Boswell, she suffered a preventable bimalleolar ankle fracture and a fifth metatarsal fracture.

(f) Failing to provide adequate supervision to prevent accidents (§483.25);

(g) Failing to maintain clinical records which are complete and accurately documented (§483.75);

(h) Failing to provide an adequate and appropriate Comprehensive Care Plan that describes the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required (§483.20);

(i) Failing to adequately and timely assess Ms. Boswell for the prevention and treatment of decubitus ulcers, and after a fall resulting in a delay in diagnosis of her left leg and ankle fractures (§483.20);

(j) Failed to take adequate and appropriate skin care precautions to prevent the development of skin breakdown and the worsening thereof;

(k) Failed to provide IRENE BOSWELL with adequate hydration;

(1) Failed to provide an adequately hygienic environment so as to prevent infection and the spread thereof;

(m) Failed to provide sufficient staff to meet IRENE BOSWELL'S needs;

(n) Failed to provide adequate nursing care;

(o) Failed to provide a safe environment;

(p) Failed to prevent broken bones and other serious injuries;

(q) Failed to follow physician's orders;

(r) Failed to notify the physician of changes in condition;

(s) Failed to provide proper care and services in accordance with resident's rights;

(t) Failed to provide watchful oversight and protective care of IRENE BOSWELL;

(u) Failed to provide adequate nursing services;

(v) Failed to obtain necessary medical services in a timely manner;

(w) Failed to properly supervise staff;

(x) Failed to properly train staff;

(y) Failed to properly perform staff retention;

47. These Defendants also have vicarious liability for the negligent acts and omissions of all persons or entities under Defendants' control either direct or indirect, including their respective employees, agents, and consultants.

48. The duty alleged in the immediately preceding paragraphs include, but is not limited to, proper training and supervision; proper hiring, background and referral checks; and proper retaining and dismissing of employees, agents, consultants and independent contractors.

Damages

49. As a direct and proximate result of the negligence of these Defendants as described herein, IRENE BOSWELL suffered injuries, physical and mental pain and suffering, disability, physical impairment, disfigurement, inconvenience, and loss of capacity for enjoyment of life. Further, she incurred medical expenses related to her injuries.

50. Plaintiff, ARETHIA JOHNSON, brings this action in her capacity as the Administrator of the ESTATE OF IRENE BOSWELL, to recover damages for the mental, physical, and emotional pain and suffering to IRENE BOSWELL that resulted from the negligence of these Defendants complained of herein, and to recover from these Defendants those medical expenses that resulted from the negligence of these Defendants.

51. These Defendants, by failing to supervise Ms. Boswell to prevent accidents such as the bimalleolar ankle fracture and a fifth metatarsal fracture she suffered and the facility was unable to identify the origin of the injury and by their failure to provide adequate services, care, and treatment, showed willful misconduct, malice, wantonness, and entire want of care that constitutes a conscious indifference to the consequences. Therefore, Plaintiff may be entitled to recover, pursuant to O.C.G.A. §51-12-5.1,

an award of punitive damages to punish, penalize and deter these Defendants, and others similarly situated, from repeating such conduct.

WHEREFORE, Plaintiff, ARETHIA JOHNSON, as Administrator of the ESTATE OF IRENE BOSWELL, demands trial by jury and judgment against these Defendants, and for compensatory and punitive damages in an amount to be determined by a jury, and such costs and attorney's fees as may be appropriate under Georgia law. To the extent that this Count may be considered a malpractice action as defined in O.C.G.A. §9-11-8 or O.C.G.A. §9-3-70, then this Plaintiff demands trial by jury and judgment against these Defendants, and for compensatory and punitive damages in an amount to be determined by a jury in excess of Ten Thousand ($10,000.00) Dollars, and such costs and attorney fees as may be appropriate under Georgia law.

COUNT III

Wrongful Death Claim Against Defendants Manor Care Rehabilitation Center of Decatur GA, LLC, and HCR Manorcare Properties, LLC

52. Plaintiff, JOHN HOLT, realleges and incorporates by reference Paragraphs 1 through 21, and Paragraphs 42 through 48 above as if they were fully set forth herein.

53. Plaintiff shows that the wrongful acts of these Defendants as set out hereunder have caused and contributed to the death of IRENE BOSWELL, who died on October 19, 2010, leaving no surviving spouse, and two children.

Damages

54. As a direct and proximate cause of the negligence of these Defendants as described herein, IRENE BOSWELL died on October 19, 2010.

55. Plaintiff, JOHN HOLT, in his Representative Capacity on Behalf of the Children of IRENE BOSWELL, brings this action on behalf of those qualified to recover damages from these Defendants for the full value of the life of IRENE BOSWELL, as set forth in O.C.G.A. §51-4-2.

WHEREFORE, Plaintiff, JOHN HOLT, in his Representative Capacity on Behalf of the Children of IRENE BOSWELL, demands trial by jury and judgment against these Defendants for damages for the full value of the life of IRENE BOSWELL in an amount to be determined by a jury, and such costs and attorney's fees as may be appropriate under Georgia law.

COUNT IV

Survival Negligence Claims against Defendant DeKalb Medical Center

56. Plaintiff, ARETHIA JOHNSON, realleges and incorporates by reference Paragraphs 1 through 12, and Paragraphs 22 through 28 above as if they were fully set forth herein.

57. By its acceptance of IRENE BOSWELL as a patient, Defendant, DEKALB MEDICAL CENTER, owed her a duty to furnish her with that degree of care, skill, and diligence required of the nursing profession in general under similar conditions and like surrounding circumstances.

58. Defendant, DEKALB MEDICAL CENTER, was negligent and failed to exercise that degree of care required of the nursing profession in general under similar conditions and like circumstances. To the extent that this Count IV may be considered a medical malpractice action as defined in O.C.G.A. §9-11-8 or O.C.G.A. §9-3-70, see the Affidavit of Mary Lynn King, RN,

BSN, CWOCN, attached as Exhibit "H" hereto pursuant to O.C.G.A. §9-11-9.1(a), to the extent that this statute may apply, if at all, to this action, and which Affidavit is hereby incorporated herein by reference. The Affidavit specifies at least one negligent act or omission on the part of Defendant, DEKALB MEDICAL CENTER, and/or its staff, and the factual basis for such negligent act or omission that caused injury to IRENE BOSWELL. The Affidavit is not inclusive of each act, error, or omission that has been committed by the Defendant, DEKALB MEDICAL CENTER, and Plaintiff reserves the right to contend and prove additional acts, errors, and omissions on the part of Defendant, DEKALB MEDICAL CENTER, that reflects a departure from the requisite standard of care required by law.

59. Notwithstanding the duty owed to IRENE BOSWELL by Defendant, DEKALB MEDICAL CENTER, as described above, the Defendant DEKALB MEDICAL CENTER was negligent and failed to exercise that degree of care, skill and diligence required of the nursing profession in general under similar conditions and like circumstances. The negligence of Defendant, DEKALB MEDICAL CENTER, included, but was not limited to, the following:
(a) On September 28, 2010, while Irene Boswell was stable, and in no acute distress, the nursing staff, agents and employees of DeKalb Medical Center were negligent and breached the applicable standard of care in the manner in which they provided care and treatment to Irene Boswell by failing to perform a proper nursing assessment and failing to provide, document or record turning or repositioning while Ms. Boswell spent nearly 10 hours on a stretcher.

(b) On September 28-29, 2010, after Irene Boswell's admission to the hospital, the nursing staff, agents and employees of DeKalb Medical Center were negligent and breached the applicable standard of care in the manner in which they provided care and treatment to Irene Boswell by failing to perform a proper nursing assessment and failing to provide, document or record turning or repositioning during the entire 11:00 p.m. to 7:00 a.m., shift and the 3:00 p.m. to 11:00 p.m. shift.

(c) On September 30, 2010, after Irene Boswell's admission to the hospital, the nursing staff, agents and employees of DeKalb Medical Center were negligent and breached the applicable standard of care in the manner in which they provided care and treatment to Irene Boswell by failing to perform a proper nursing assessment and failing to use, document or record placement of heel protective devices as ordered for her heel pressure sores during the entire day.

60. Defendant, DEKALB MEDICAL CENTER, also has vicarious liability for the negligent acts and omissions of all persons or entities under Defendant, DEKALB MEDICAL CENTER'S, control either direct or indirect, including their respective employees, agents, and consultants.

61. The duty alleged in the immediately preceding paragraphs include, but is not limited to, proper training and supervision; proper hiring, background and referral checks; and proper retaining and dismissing of employees, agents, consultants and independent contractors.

Damages

62. As a direct and proximate result of the negligence of Defendant, DEKALB MEDICAL CENTER, as described herein, IRENE BOSWELL suffered injuries, physical and mental pain and suffering, disability, physical impairment, disfigurement, inconvenience, and loss of capacity for enjoyment of life. Further, she and/or her Estate incurred medical and funeral expenses related to her injuries and her subsequent death.

63. Plaintiff, ARETHIA JOHNSON, brings this action in her capacity as the Administrator of the Estate of IRENE BOSWELL, to recover damages for the mental, physical, and emotional pain and suffering to IRENE BOSWELL that resulted from the negligence of Defendant, DEKALB MEDICAL CENTER, complained of herein, and to recover from the Defendant, DEKALB MEDICAL CENTER, those medical expenses that resulted from the negligence of Defendant, DEKALB MEDICAL CENTER.

64. This Defendant, on September 28, 2010, while Irene Boswell was stable, and in no acute distress, by failing to perform a proper nursing assessment and failing to provide, document or record turning or repositioning while Ms. Boswell spent nearly 10 hours on a stretcher and by its failure to provide adequate services, care, and treatment, showed willful misconduct, malice, wantonness, and entire want of care that constitutes a conscious indifference to the consequences. Therefore, Plaintiff may be entitled to recover, pursuant to O.C.G.A. §51-12-5.1, an award of punitive damages to punish, penalize and deter this Defendant, and others similarly situated, from repeating such conduct.

WHEREFORE, Plaintiff, ARETHIA JOHNSON, as Administrator of the ESTATE OF IRENE BOSWELL, demands trial by jury and judgment against Defendant DEKALB MEDICAL CENTER and, for compensatory and punitive damages in an amount to be determined by a jury, and such costs and attorney's fees as may be appropriate under Georgia law. To the extent that this Count may be considered a malpractice action as defined in O.C.G.A. §9-11-8 or O.C.G.A. §9-3-70, then this Plaintiff demands trial by jury and judgment against Defendant DEKALB MEDICAL CENTER for compensatory damages in an amount to be determined by a jury in excess of Ten Thousand ($10,000.00) Dollars, and such costs and attorney fees as may be appropriate under Georgia law.

COUNT V

Wrongful Death Claim Against Defendant DeKalb Medical Center

65. Plaintiff, JOHN HOLT, realleges and incorporates by reference Paragraphs 1 through 12, Paragraphs 22 through 28, and Paragraphs 56 through 61, above as if they were fully set forth herein.

66. Plaintiff shows that the wrongful acts of the Defendants as set out hereunder have caused and contributed to the death of IRENE BOSWELL, who died on October 19, 2010, leaving no surviving spouse, and two children.

Damages

67. As a direct and proximate cause of the negligence of the Defendants as described herein, IRENE BOSWELL died on October 19, 2010.

68. Plaintiff, JOHN HOLT, in his Representative Capacity on Behalf of the Children of IRENE BOSWELL, brings this action on behalf of those qualified to recover damages from Defendants for the full value of the life of IRENE BOSWELL, as set forth in O.C.G.A. §51-4-2.

WHEREFORE, Plaintiff, JOHN HOLT in his Representative Capacity on Behalf of the Children of IRENE BOSWELL, demands trial by jury and judgment against Defendants for damages for the full value of the life of IRENE BOSWELL in an amount to be determined by a jury, and such costs and attorney's fees as may be appropriate under Georgia law.

JURY DEMAND

Pursuant to O.C.G.A. §15 -12 - 122, Plaintiff demands a full jury panel of 12 to try this case.

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